STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155783	A. BUILDING 00 B. WING	09/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENLEAF HEALTH CAMPUS	1201 E BEARDSLEY ELKHART, IN 46514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Recertification and State Licensure Survey. Survey dates: September 17, 18, 19, 20, 21, 24, 25, and 26, 2012 Facility number: 002661 Provider number: 155783 AIM number: n/a Survey team: Shelly Vice, RN-TC Carol Miller, RN Honey Kuhn, RN (9/20, 9/21, 2012) Debra Kammeyer, RN (9/24, 9/25, 9/26, 2012) Census bed type: SNF: 20 NF: 7 SNF/NF: 29 Residential: 47 Total: 103 Census payor type: Medicare: 20 Medicaid: 7 Other: 76 Total: 103	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Greelleaf Health Campus was found to be in substantial compliance with 42 CFR part 483 subpart B in regard to the Recertification Survey. These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 9/28/12 Cathy Emswiller RN			

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F0223 SS=A	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interviews and record reviews, the facility failed to ensure that 3 of 3 residents reviewed were free from physical abuse in a sample of 40. (Residents #6 and discharged Residents #84, and #200). **Findings Include:** 1. The Resident Concern form dated 6/14/12 at 9:30 a.m. indicated Resident # 84 had complained CNA #2 had been rough with her during care on 6/13/12 at 6:00 p.m. The resident did not report the incident until 6/14/12 at 9:30 a.m. The Resident Concern form indicted the DNS had inserviced the nursing staff in regard to reporting allegations of abuse and residents rights. On 6/14/12 CNA #2 was suspended from the facility pending an investigation of the abuse. 2. The Resident Concern form dated 6/14/12 indicated Resident # 84 had complained CNA #2 had been rough with her during care. 3. The Resident Concern Form indicated the date of the concern dated 6/13/12 at 11:15 indicated Resident #6 had complained CNA #2 was rough with her during care.	F0223	The CNA #2 was suspended on 06/14/12 and termed on 06/19/12 after investigation completed due to not meeting facility service standards, CNA was rude and the residents felt she was rough. None of the residents were harmed.All staff are inserviced on resident rights and abuse upon hire and yearly. All staff were re-inserviced on resident rights and abuse on 06/15/12 and educated on reporting of any suspected abuse of any kind and the procedures expected of them as care givers. Morning meeting any resident or family concerns are addressed and discussed on a daily basis with follow thru if needed. Quality Assurance goes over all concerns monthly which is ongoing. Procedure was followed correctly. If in QA no concerns or reports of residents not being treated accordingly is presented after 6 months then the issue will be dismissed. Resident Council Leader will be ask to discuss in monthly meeting any issues with staff not acting appropriately and in that meeting	09/27/2012

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	The Quarterly Minimum Data Set Assessment date 8/2/12 indicated the resident had no cognitive impairment. On 9/18/12 at 10:21 a.m. an interview with Resident #6 in regard to how the staff had treated the resident and indicated she had been treated roughly during her care by a CNA who no longer worked at the facility. Resident #6 declined to give the CNA's name. The Administrator indicated Resident #84 had not told the DNS (Director Nursing Services) until the next day the CNA #2 had been rough with her during personal care. The Administrator indicated CNA #2 was suspended immediately on 6/14/12 and an investigation was initiated and reported to the Indiana Department of Health on 6/14/12 according to the Abuse policy. On 9/19/12 at 10:20 p.m. the DNS was interviewed in regard to abuse the DNS indicated on 6/14/12 Resident #84 had told her CNA had treated her roughly. The DNS indicated CNA was suspended and Resident #6 and #200 were interviewed and both residents indicated on 6/13/12 CNA had been rough with them. The DNS indicated CNA #2 employment was terminated on 6/19/12 at the facility. **The Administrator provided the Abuse and Neglect Policy on 9/19/12 at 9 a.m. and was reviewed and indicated "...c. Physical Abuse-includes...handling roughly...."** **3.1-27(a)(1)**		residents rights are gone over to refresh the residents attending and to ensure they understand what there rights are. 06/19/12.	

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R0000	These state residential findings are cited in accordance with 410 IAC 16.2.	R0000		

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R0033	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observations and interviews the facility failed to provide a posting of current addresses and telephone numbers for contacting the state and local agencies for complaints of residents. This deficient practice had the potential to affect 44 of 44 residents residing in the facility. Findings included: Upon entrance to the facility on 9/24/12 at 2:30 p.m. an observation was made of the facility. A current listing of contact numbers and addresses for the local, state	R0033	1. The current listing of contact numbers and addresses for local, state and federal agencies was reposted on 09/24/12.2. No residents were affected negatively.3.Housekeeping will check 1x weekly for 30 days when cleaning lobby to ensure all postings remain in the lobby visible for all residents and families.4. The Administrator will also check 1x weekly for 30 days to ensure listing is posted and visible to all residents and families. Resident council leader will be ask to discuss in resident council monthly x3 where the listing is posted and if any	09/27/2012

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	and federal agencies for resident use was not posted in an area visible to residents, staff, and the public.. On 9/24/12 at 3:00 p.m. an interview was conducted with the Administrator regarding the location of current listings of contact numbers and addresses for the local, state and federal agencies in the facility. She noted that she was not aware that it was not located in the entrance foyer area. She indicated that they (the listings) had been on the wall out side the public bathroom in the foyer area and she was not aware where they had been relocated. On 9/25/12 at 9:00 a.m. an observation was made of the current listings of the contact numbers and addresses for the local, state and federal agencies for resident concerns. It was located in the foyer area outside the public bathroom. It was in a large black frame and included yet not limited to: the state department, the office of the secretary of family and social services, the ombudsman, the area agency on aging, the local mental health center and adult protective services. On 9/25/12 at 10:00 a.m. an interview was made with the Maintenance Director. He indicated that he was unaware that listing of contact numbers and addresses		difficulties are noted. 5. 09/25/12	

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	had not been located in the foyer entrance of the facility. On 9/25/12 at 2:00 p.m. an interview was conducted with the Administrator. She indicated that the contact information for the concerned agencies had not been reposted after a frame change had been made at an earlier date. On 9/26/12 at 10:00 a.m. an interview with the Administrator and DNS and Corporate Nurse Consultant indicated that there had been a copy in the foyer entrance area "... a while back..." and had not been replaced. They indicated it had been placed in the foyer area.			

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R0042	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observations and interviews the facility failed to provide a copy of the annual survey for public access. This deficient practice had the potential to affect 44 of 44 residents in the facility. Findings include: Upon entrance to the facility on 9/24/12 at 2:30 p.m. an observation was made in the foyer at the entrance of the facility. A copy of the most recent survey was not posted in an area visible to residents, staff, and the public. On 9/24/12 at 3:00 p.m. an interview was conducted with the Administrator regarding the location of the most recent annual state survey of the facility. She noted that she was not aware that it was not located in the entrance foyer area. On 9/25/12 at 10:00 a.m. an interview was made with the Maintenance Director. He indicated that he was unaware that a copy of the most recent annual survey was not located in the foyer entrance of the	R0042	1. The copy of the State survey was re-placed in the main entrance on the Assisted Living, in a binder labeled state survey results on 09/25/12.2. No residents were affected negatively and a copy was available on the health care side.3. Housekeeping will check 1x weekly x 30 days when cleaning lobby to ensure book is available and visible to all residents and families.4. Administrator will also check 1x weekly x 30 days to ensure state survey results binder is visible and available to residents and families. The Resident Council leader has been ask to discuss in Resident council meeting about the State Survey Book and its location monthly x 3 so all residents are aware binder.5. 09/25/12	09/27/2012

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	facility. On 9/25/12 at 2:00 p.m. an interview with the DNS indicated that a copy of the most recent annual survey was now located in the entrance foyer. On 9/26/12 at 10:00 a.m. an interview with the Administrator and DNS and Corporate Nurse Consultant indicated that there had been a copy in the foyer entrance area "... a while back..." and had not been replaced. They indicated it had been placed in the foyer area.			

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R0121	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			

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	Based on interview and record review the facility failed to ensure a timely Two Step Mantoux PPD (purified protein derivative) was completed for 1 of 5 employee files reviewed (CNA #1). Findings include: On 9/25/12 at 10:30 a.m., CNA #1 employee file was reviewed and indicated CNA was hired on 5/30/12 and her first Mantoux was done on 3/16/12. There was no record of a Two Step Mantoux being completed upon hire or within one month prior to employment. On 9/25/12 at 12:15 p.m., the DNS (Director of Nursing Services) provided an undated policy entitled, "Guidelines for TB (tuberculosis) Results Summary Documentation: Staff". The policy was reviewed and indicated , "Upon hire each employee shall receive a Two Step Mantoux PPD test to ensure they are free of tuberculosis". On 9/26/12 at 8:50 a.m., during interview with the DNS indicated CNA #1 was hired on 5/30/12 and received her Mantoux PPD while in school on 3/16/12 and was read on 3/19/12 with zero induration(negative finding for TB). The DNS also indicated CNA #1 did not receive the required Two Step Mantoux	R0121	1. Employee #1 was given a step 1 mantoux and is scheduled for a step 2 mantoux.2. All employee files were audited to ensure all mantouxs are current in files with 1st and 2nd step mantouxs.3. The Human Resources person will have a tracking form of new employees when hired and will have dates of when they are due for their mantoux. These dates will be given to appropriate department head and they will ensure that employee gets their mantoux completed.4. The Human Resources person and or her designee will audit all new hires within two weeks to ensure step 2 mantouxs have been completed timely. Quality Assurance Committee will discuss audit findings monthly x3 and if 100% compliance is accomplished then the QA team will decide whether to continue to monitor or consider issue resolved with current system.5. 10/19/12	10/19/2012

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R0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observations and interviews the facility failed to assure a disinfectant was locked in the beauty shop, a clean supply room was locked and a biohazard room was latched to prevent access to residents in the facility. This deficient practice had the potential to affect 44 of 44 residents residing at the facility. Findings include: 1). On 9/24/12 at 2:45 p.m. an observation was made of the beauty shop entry door. The door was closed, the lights were off and the door was unlocked. An interview was conducted	R0148	1. An automatic closer was put on beauty shop door on 09/26/12. The beautician was inserviced on the importance of door being locked when no one is in salon due to chemicals. A key pad lock was placed on the storage closet door on 09/25/12 that locks automatic, no are only personal items in this storage no chemicals. 2. No residents were affected negatively by this.3. Plant ops will check 1x weekly x 30 days to ensure self closure is closely correcting and that key pad is working correctly to both areas.4. Administrator will also check 1x weekly to ensure these areas are properly secured when not in use. Quality Assurance will	09/28/2012

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	with LPN#4 to whether the door to the beauty shop was to be locked when no on was in the shop. She had affirmed this. On 9/24/12 at 3:00 p.m. an observation was made of the beauty shop. The beauty shop was opened, lights were on and there was no one in the beauty shop upon entering the area. It was noted that an unlocked cabinet contained a chemical for disinfecting hair supplies. This disinfectant was labeled 'barbacide' and a warning label was not visualized. It was found to be unlocked. The beauty shop was located with accessibility to the public and residents. An interview at 3:02 p.m. was conducted with a LPN#2. A big container labeled 'barbacide' was noted. She indicated there was opportunity to lock the chemical yet upon observation it was unlocked. It was also noted that a variety of snack food items were stored alongside a bottle of barbacide. An interview was conducted with the Maintenance Director on 9/25/12 at 10:00 a.m.. It was indicated that the beauty shop was to be locked when not in use or if the beautician was not in the shop. It was indicated that a chemical, barbacide, was to be locked and food was not to be stored beside the disinfectant of		monitor monthly x 3 to ensure the door is locking correctly and if no issues will consider area in compliance and dismiss from QA. 5. 09/27/12	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	barbacide. 2). On 9/25/12 at 10:30 a.m. an observation was made of an unlocked and unlabeled storage closet located in the hall to the foyer to the front entrance. The closet was used to store personal supplies such as non-alcoholic mouthwash, sanitary personal items, and other hygienic personal supplies. There was a handwritten note taped to the shelving unit indicating that items removed from the closet should be charged to the resident that is using the items. On 9/25/12 at 2:00 p.m. an interview was conducted with the Maintenance Director. When he was requested to open the door to the supply closet, he immediately reached for his facility keys. It was noted that a key was not required due to the closet being unlocked. He indicated that whether the closet should be locked was in question. On 9/26/12 at 7:30 a.m. an observation was made of the supply closet and found to have a push button lock secured above the handle. 3).On 9/25/12 at 1:45 p.m. an observation was made of the biohazard storage closet located on Hall C. Upon twisting the locked handle of the biohazard door, it			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155783	A. BUILDING 00 B. WING	09/26/2012

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	was found to be unlatched and was able to be pushed open without any resistance. A red bag was able to be visualized from the opening. Upon returning the door to a closed position, the door latched and was then locked and unable to be pushed open. On 9/25/12 at 2:15 p.m. an interview with the Maintenance Director was conducted. It was noted that the biohazard closet doors were locked and inaccessible to be opened without a key.			